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	085001	A. BUILDING _____ B. WING _____	09/07/2017

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KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 29, 2017 through September 7, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 98. The Stage 2 survey sample size was 25. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; cm - centimeters, measurement of length; DON - Director of Nursing; ER-emergency room; LPN- Licensed Practical Nurse; MAR - Medication Administration Record; MD - Medical Doctor or physician; MDS - Minimum Data Set, standardized assessment forms used in nursing homes; mg - milligram measurement of weight; NHA- Nursing Home Administrator; POA - Power of Attorney, someone appointed to make decisions on your behalf ; PRN - as needed; PT - physical therapy; RN- Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Blanchable - skin loses redness with pressure; Coccyx - tailbone; Cognitive Deficit - mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Dementia - persistent disorder of the mental processes caused by brain disease or injury and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/26/2017

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F 000	Continued From page 1 marked by memory disorders, personality changes, and impaired reasoning; Dementia with Lewy bodies - a type of dementia that worsens over time; may include fluctuations in alertness, visual hallucinations, slowness of movement, trouble walking, and rigidity; Depression- mental disorder with feelings of sadness; Gait - manner of walking; Insomnia - difficulty falling and staying asleep; Misappropriation - the intentional, illegal use of the property or funds of another person for one's own use or other unauthorized purpose; Neurologist - specialized doctor who treats disorders that affect the brain, spinal cord and nerves; Peri-wound - skin around the wound; Physiatrist / Physiatry - medical doctor who specializes in physical medicine, rehabilitation and pain medicine; Psychotherapeutic - treatment for mental or emotional disorder; Psychotropic - any drug (medication) capable of affecting the mind, emotions, and behavior; Restorative Nursing - interventions to promote the resident's ability to adapt and adjust to living as independently and safely as possible; Sacrum / Sacral - large triangular bone at the base of the spine; Serous - thin, clear, light yellow watery fluids found in many body cavities; Stroke - medical condition involving reduced blood supply to the brain from a blood clot; Trazodone - medication used for depression that can cause drowsiness and is at times prescribed for insomnia.	F 000		
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		11/27/17

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F 224	Continued From page 2 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documents, it was determined that the facility failed to ensure abuse training was provided for one out of 8 employees interviewed. E5 (beautician), was not able to identify potential abuse and did not know how to handle reports of resident abuse, including whom to report to. Findings include: Review of the facility policy, dated April 2017, and entitled Abuse, Neglect, Mistreatment, Misappropriation and Exploitation stated, "All employees, contracted providers, and volunteers upon hire, and annually thereafter, will receive mandatory training on issues related to abuse,	F 224	1. No resident was harmed by this deficient practice. Abuse training was conducted for the beautician upon discovery. 2. All residents have the potential to be affected by this deficient practice. 3. The facility completed a sweep of all vendors that provide direct care to the residents and it was determined that no other residents were affected by this practice. The facility did not have an internal process in place for monitoring abuse training for vendors. All vendors upon contractual agreement and annually will receive Abuse/Neglect training. Current vendors who provide direct care	

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F 224	Continued From page 3 neglect, mistreatment, misappropriation of resident property and exploitation, consistent with their expected roles, pursuant to the Training Policy". On 9/7/17 at 11:14 AM, E5 (contracted beautician) was interviewed regarding reporting observed or suspected abuse or mistreatment. E5 stated that she had worked at the facility for about one year. E5 stated that she had never observed any mistreatment of residents, nor had she been told of any abuse or mistreatment of residents. When questioned about what she would do if a resident reported to her that they had been abused or mistreated, E5 stated she "would wait to see if they told her the same thing the next time she saw them, and if they did she would probably tell the Nursing Home Administrator". On 9/7/17 at approximately 3:30 PM, findings were discussed with E2 (DON) and E4 (ADON). On 9/7/17 at 3:57 PM E2 reported that E5 was not trained on issues related to abuse, neglect, mistreatment, misappropriation of resident property and exploitation. Findings were reviewed with E2 (DON) and E4 (ADON) on 9/7/17 at approximately 3: 30 PM.	F 224	will receive Abuse/Neglect training annually thereafter. 4. The Staff Educator/designee will complete a random audit monthly until 100% compliance is achieved for 3 consecutive months and on going as needed. The compliance rate will be reported at the facility Quality Assurance Meeting.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who-	F 225		11/27/17

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F 225	Continued From page 4 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 225		

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F 225	Continued From page 5 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of facility documentation, it was determined that the facility failed to report a fall with injury that required hospital treatment to the DLTCRP (Division of Long Term Care Residents Protection) State agency within 24 hours and they failed to submit a 5 day follow up for one (R8) out of 25 Stage 2 sampled residents. R8 fell on 1/3/17, was sent to the ER (emergency room) and received stitches for a cut in her eyebrow. Findings include: 1. Review of R8's clinical record revealed the following: R8 resides in the locked dementia unit of the facility. She has both short and long term memory problems according to a 7/2/17 annual MDS.	F 225	1. R8 was not harmed by this deficient practice. 2. All residents have the potential to affected by this deficient practice. 3. A facility wide sweep was conducted and it was determined that the facility failed to report a fall with injury on one like resident. An internal audit was conducted and no other residents were identified. The facility identified that a new process would be needed to ensure that all injuries sustained in the facility will be reviewed and reported as appropriate according to the guidelines of the Division of Long Term Care. The Nursing Supervisors will be trained on the process for electronically reporting incidents that are reportable to the Delaware Division of Long Term Care Resident Protection within eight hours of	

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F 225	Continued From page 6 R8 fell on 1/3/17 and was sent to the ER where she received 3 stitches to her right eyebrow. While reviewing the facility's investigation of the fall, there was no documentation that the facility reported the fall to the DLTCRP State agency within 24 hours and no documentation of a 5 day follow up being sent to the DLTCRP. During an interview with E2 (DON) on 9/7/17 at 11:20 AM, E2 confirmed that R8's 1/3/17 fall with injury that required the resident to be sent to the hospital and treated was not reported to the DLTCRP. Findings were reviewed with E2 (DON) and E4 (ADON) on 9/7/17 at approximately 3: 30 PM.	F 225	the incident and how to determine which incidents are reportable. 4. The DON/Designee will audit all resident incidents weekly until 100% compliance is achieved x 3 consecutive months and ongoing as needed. The compliance rate will be reported at the facility Quality Assurance Meeting.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		11/27/17

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F 309	Continued From page 7 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for one (R15) out of 25 Stage 2 sampled residents. For R15, the facility failed to implement interventions listed on R15's care plans to address her confusion, crying and distress on 8/31/17 when R15 thought she was lost. Findings include: Review of R15's clinical record revealed: R15's most recent MDS assessment, dated 6/7/17, coded R15's cognitive patterns as severely impaired (never/rarely made decisions). R15's care plan for Dementia/Cognitive Deficits,	F 309	1. R15 was not harmed by this deficient practice. Staff were inserviced on specific psychosocial interventions per the plan of care. Resident will be observed at least weekly to assure that the psychosocial plan of care is implemented until substantial compliance is achieved for three consecutive months. 2. All residents have the potential to be affected by this deficient practice. 3. It was detervmined that the facility failed to follow R15's care plan for interventions to provide the highest practical mental and psychosocial well-being when a resident was in need of staff intervention. The Nursing staff will be in-serviced on following care plan interventions as it relates to their psychosocial well-being. 4. Social Service Director/designee will	

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F 309	Continued From page 8 effective 9/7/16, listed interventions to: Allow resident ample time to absorb and respond to information ... Understand that people with dementia do not have access to logic. R15's care plan for Social Services-Mood/Verbalizing Negative Statements, effective 9/7/16, listed an intervention to: Calmly reassure resident. R15's care plan for Social Services - False Beliefs/Accusations, Resident presents with false beliefs/accusations crying, getting upset ..., effective 12/20/16, had interventions to: Listen to resident's thoughts ... Calmly explain ...; and Redirect her .... On 8/31/17 at 3:10 PM, the surveyor was on the 2nd floor in the doorway between the dining room and the common area. At 3:11 PM on 8/31/17, R15 approached the surveyor using a walker. R15 was crying and stated, "Will you help me? I'm lost". Surveyor responded, "The nurses will help you, let's go get the nurse". R15 continued crying and stated, "they won't help me, I'm lost". The surveyor walked R15 toward the nurse's station where 8 staff members were standing/sitting during the change of shift. Some of the staff turned to watch the surveyor and R15 approach. R15 was crying and stated again, "they won't help me, I'm lost". The surveyor replied, "the nurses will help you". No staff responded to R15. The resident stated "they don't help me". Surveyor asked E3 (LPN) the resident's room number. E3 responded with R15's room number.	F 309	complete 10 random observation audits on residents who exhibit behaviors to ensure that staff is adhering to care plan interventions as it relates to psychosocial well-being monthly until 100% compliance is achieved x 3 consecutive months and on-going as needed. The compliance rate will be reported to the Quality Assurance meeting.	

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F 309	Continued From page 9 The surveyor walked R15 down the hallway to her room. R15 continued crying and stating, "I'm lost". The surveyor and R15 entered resident's room where the surveyor remained with R15 for approximately 15 minutes until R15 stopped crying and was calm. No staff came to the room to check on R15 while the surveyor was there. When the surveyor walked back past the nurse's station, no staff approached the surveyor and inquired about R15. The facility failed to follow R15's care plan to provide the highest practicable mental and psychosocial well-being, when R15 was upset, crying and repeatedly stating she was lost, and staff did nothing to assist the resident. Findings were reviewed with E2 (DON) and E4 (ADON) on 9/7/17 at approximately 3:30 pm.	F 309		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences	F 329		11/27/17

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F 329	Continued From page 10 which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to monitor the effectiveness of Trazodone for one (R45) out of 25 Stage 2 sampled residents. Findings include: Review of R45's clinical record revealed the following: 5/11/17 - R45 was admitted to the facility with diagnoses that included dementia with Lewy bodies, depression and insomnia. 5/11/17 - A physician's order stated that R45 was to receive Trazodone 50 mg one (1) tablet PRN at	F 329	1. R45 was not harmed by this deficient practice. All prn medication was reviewed and effectiveness was added to the electronic record as a default, to assure that effectiveness is noted with each administration. 2. Prn medication is being reviewed for all residents. Any resident with a prn medication will have an effectiveness default added to the order. 3. It was determined that the facility failed to monitor the effectiveness of a medication for R45. Staff Educator will in-service nursing staff on adding effectiveness to all prn orders. Staff	

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F 329	Continued From page 11 bedtime for insomnia. 5/24/17 - A care plan was developed for psychotropic drug use related to depression and insomnia. Interventions included to assess need for psychotherapeutic medication and assess effectiveness of the medication. Review of MARs from 5/11/17 through 8/30/17 revealed that R45 received Trazodone on the following dates: 5/12/17, 5/17/17, 5/20/17, 6/16/17, 7/2/17, 7/16/17, 7/23/17, and 8/6/17. Review of behavior monitoring sheets, MARs and progress notes revealed the lack of monitoring of effectiveness of the Trazodone on the above listed dates. 8/31/17 at 10:25 AM - Findings were reviewed with E2 (DON). E2 confirmed the facility failed to monitor the effectiveness of the Trazodone.	F 329	Developer will inservice nurses also to document the effectiveness of PRN medications that are ordered. 4. ADON/designee will complete a random weekly audit on 10 residents on each floor who receive PRN Medications to ensure that follow-up monitoring was documented as appropriate until 100% compliance is achieved for 3 consecutive months and ongoing as needed. The Compliance rates will be reported at the Quality Assurance meeting.	
F 385 SS=D	483.30(a)(1)(2) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN §483.30(a) Physician Supervision. The facility must ensure that-- (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that for one (R177) out of 25	F 385	1. R177 was not harmed by this deficient practice.	11/27/17

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F 385	Continued From page 12 Stage 2 sampled residents, the facility failed to ensure that a physician was supervising the medical care of R177, specifically from 7/22/16 through 8/11/16, when R177 was identified with a skin lesion/growth on her coccyx/sacrum which later became an open wound. Findings include: Review of R177's clinical record revealed the following: 7/21/16 at 3:38 PM - A progress note stated that R177 had a skin lesion/growth on her coccyx and the facility's physician was notified. 7/22/16 at 12:16 PM - A progress note by E4 (ADON/Wound Care Nurse) stated that she was asked to assess R177's coccyx/sacrum regarding a skin lesion/growth. E4 stated that R177 had a raised 1.0 cm x 1.0 cm red to black area with no drainage, the skin around the area was blanchable, there was hair present throughout the skin lesion/growth and R177 had pain when the area was touched. E4 stated that the "MD (physician) to evaluate on this day." Review of the clinical record revealed lack of evidence that a physician evaluated R177 on 7/22/16. 7/29/16 at 2:49 PM - A progress note by E4 stated that she was asked to re-assess R177's coccyx/sacrum regarding the skin lesion/growth which was now an open wound. E4 stated that R177's raised area was now open measuring 1.0 x 1.0 x 0.1 cm with a tan wound bed, scant amount serous drainage and fleshtone peri-wound. E4 stated that the "MD to assess area...MD to evaluate." Review of R177's clinical record from 7/22/16 through 8/11/17 revealed lack of evidence that R177 was seen and evaluated by a physician regarding her open	F 385	2. All residents have the potential to be affected by this deficient practice. 3. A facility sweep was conducted on all residents with skin conditions and it was determined that no other residents were affected by this practice. A route cause analysis was completed and it was determined the facility failed to ensure that the provider assessed R177's skin lesion/growth on her coccyx/sacrum which resulted in an open area. The facility will notify the physician immediately upon identification of new skin conditions, as well as provide a weekly list of ongoing skin conditions that require assessment by the provider to ensure a proper assessment was completed. The provider will review listed residents to evaluate and to document status of the skin condition in the medical record as needed. 4. ADON/designee will conduct a weekly audit on all resident skin conditions to ensure provider notification of new skin conditions and needed assessment of ongoing wounds was completed weekly until 100% compliance is achieved for 3 consecutive months and ongoing as needed. The Compliance rate will be reported at the facility Quality Assurance meeting.	

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	085001	A. BUILDING _____ B. WING _____	09/07/2017

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F 385	Continued From page 13 wound. 9/5/17 at 4:16 PM - During a combined interview, E4 (ADON) and E9 (RNAC) stated that they both were in R177's room on 7/22/16. E4 stated that she assessed the skin lesion/growth while E9 was translating as the R177's primary language was Spanish. E9 stated that she observed R177's skin lesion/growth on 7/22/16 and described the area as a "bump or mole". 9/5/16 at 5:01 PM - During an interview, E10 (LPN) stated that she was the nurse who first identified the skin lesion/growth on R177's coccyx on 7/21/16. E10 stated that the area was not a blister or a mole. E10 stated that she was very familiar with R177 as she toileted her often and had never seen the skin lesion/growth before. E10 stated that she notified the physician and referred it to the wound care nurse, E4, to be assessed further. 9/6/17 at 4:36 PM - During a combined interview, E2 [DON] and E4 confirmed the findings. The facility failed to ensure that R177 was evaluated by a physician from 7/22/16 through 8/11/16 when a skin lesion/growth was identified on her coccyx/sacrum which later became an open wound.	F 385		
F 406 SS=E	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser	F 406		11/27/17

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F 406	Continued From page 14 intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that for one (R142) out of 25 Stage 2 sampled residents, the facility failed to obtain and coordinate specialized rehabilitative services from an outside rehabilitation center per a 4/10/17 facility physician's order within a reasonable timeframe. Findings include: Review of R142's clinical record revealed the following: 12/12/16 - R142 was admitted to the facility for rehabilitation after a stroke resulting in right sided weakness. 12/13/17 through 2/2/17 - R142 received rehabilitative services from the facility's inhouse physical therapy (PT) department. 2/3/17 at 12:48 PM - The facility's inhouse PT discharge summary stated that R142 achieved his highest practical level and restorative nursing care was not appropriate at the time "due to inconsistent abilities and tone changes" on the right side of his body.	F 406	1. R142 was not harmed by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. A facility sweep was conducted and it was found that no other residents were affected by this practice. It was determined that the facility failed to coordinate specialized rehabilitative services for one resident to an outside rehabilitation center within a reasonable time period. A root cause analysis was completed and it was determined that order for Outpatient Specialized Therapy was not completed in a timely fashion related to extenuating circumstances, including the receiving Therapy facility billing and family transpiration issues, with a lack of documentation by the facility. All new orders for external therapy services will be reviewed during AM Meeting to ensure timely coordination of services, including billing and transportation, along with family notification as appropriate. 4. The Therapy Director/Designee will	

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F 406	Continued From page 15 2/28/17 - R142 was seen by C1 (neurologist) who recommended a physiatry evaluation to discuss resuming therapy. 3/8/17 at 2:43 PM - The facility's inhouse PT assessed R142 at the request of C1. The facility's PT evaluation stated that R142's functional mobility skills remained unchanged since his inhouse therapy discharge on 2/3/17 and treatment was not recommended at this time. 3/28/17 at 10:14 AM - A progress note stated that R142's POA (unidentified #1 or #2) insisted on scheduling an appointment with C2 (physiatrist), which was arranged for 4/7/17 at 1 PM. 4/7/17 - R142 was seen by C2 and received a referral for physical therapy two times a week for six weeks. In addition, a follow-up appointment with C2 was scheduled on 6/6/17 at 12:30 PM, approximately eight weeks later. 4/10/17 at 3:23 PM - The facility's physician order stated to refer R142 to an outside rehabilitation center for physical therapy two times a week for six weeks. 5/1/17 at 9:37 AM - The facility's physician order stated to follow-up with C2 on 8/8/17 at 1 PM. 5/31/17 - The facility's physician order stated that R142 had a consult at an outside rehabilitation center on 6/1/17 at 10 AM with medical transportation arranged. 6/1/17 at 12:29 PM - A facility's progress note stated that R142 returned from the outside rehabilitation center with no new orders.	F 406	conduct weekly audits on all residents who have an order to receive external therapy services to ensure that documentation is in place to address the coordination of services. This audit will be conducted weekly until 100% compliance is achieved for 3 consecutive months and ongoing as needed. The Compliance rate will be reported at the facility Quality Assurance meeting.	

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F 406	Continued From page 16 6/6/17 at 10:20 AM - The facility's physician order stated that the facility's inhouse therapy services to screen, evaluate and treat R142. 6/6/17 at 5:23 PM - The facility's inhouse PT evaluation stated that another family member of R142 asked that he be re-evaluated for transfer and gait training in addition to educating the family on how to transfer him so they could take him to family functions. The evaluation stated that R142 continued to "lack sufficient motor control needed to advance his functional mobility skills" and treatment was not recommended. 6/6/17 at 5:34 PM - The facility's physician order stated to discontinue the facility's inhouse therapy services order dated 6/6/17 to treat R142. 7/14/17 - The facility's Rehab Screening Form stated E8 (Rehab Director) spoke with F2 (POA #2) regarding R142's cognitive status and the need for 24 hour care because of safety concerns and his lack of insight regarding his abilities. E8 stated that R142 does not appear at the current time "to have further potential to reach a greater independence of mobility...". E8 stated that the family "wishes to pursue a second opinion from outside therapy...". 7/26/17 at 6:13 PM - The facility's physician order stated to refer R142 to an outside rehabilitation center for physical therapy with the following schedule: 8/4/17 at 11:30 AM, 8/8/17 at 11:30 AM and 8/16/17 at 2:30 PM. It was unclear why it took the facility approximately 4 months to obtain and coordinate outside therapy services for R142 when the facility's physician ordered the specialized services on 4/10/17.	F 406		

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F 406	Continued From page 17 8/30/17 at 10:57 AM - During an interview, F1 (POA #1) stated that the facility delayed in obtaining therapy services for R142 eventhough C2 referred him for additional therapy. F1 stated that it had been a very difficult situation trying to obtain outside therapy services. F1 stated that R142 was finally receiving therapy services now at an outside rehabilitation center. 9/6/17 at 3:14 PM - During an interview, E8 stated the following: - on 3/8/17, the facility's inhouse PT evaluated R142 per a neurologist consult and determined that R142 was at his baseline; - on 3/23/17, the facility's inhouse OT evaluated R142's right hand and ordered a splint; - on 6/6/17, R142's family member asked the facility's inhouse PT if they could help them with taking R142 home for family functions (transfers, toileting). The facility's inhouse PT evaluated R142 on 6/6/17 and then called F1 (POA #1) to discuss options. F1 declined the facility's inhouse PT services and told them he was looking at other outside rehabilitation options for R142; and - on 7/14/17, E8 attempted to contact F1 without success and then called F2 (POA #2). F2 stated that he was looking at other rehabilitation options. 9/6/17 at 4:39 PM - During an interview, E4 (ADON) stated that there were delays due to billing issues regarding therapy services between the facility's inhouse PT and the outside rehabilitation center in addition to delays in arranging for medical transportation to the outside rehabilitation center. E4 stated that the facility's former social worker was directly involved but was no longer employed there. It was unclear exactly how the facility's former social worker was	F 406		

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F 406	Continued From page 18 involved as R177's clinical record lacked evidence of social services documentation. 9/6/17 at 4:45 PM - Findings were reviewed and confirmed with E2 (DON) and E4 (ADON). The facility failed to obtain and coordinate specialized rehabilitative services from an outside resource per a 4/10/17 facility physician's order for R142 within a reasonable timeframe. On 8/4/17, approximately 4 months later, R142 received specialized PT services at an outside rehabilitation center.	F 406		
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain a properly functioning communication system used by residents to contact staff in 3 out of 35 rooms. Findings include: 1. During a review of the environment on 8/30/17 from 2 PM to 4 PM with E6 (Maintenance Director) and E7 (Housekeeping Director), the hallway light outside of room 104 did not turn on when activated by pulling the call bell cords in the bedroom and bathroom.	F 463	1. No residents were harmed by this deficient practice. The call cord and light were repaired upon discovery. 2. All residents have the potential to be affected by this deficient practice. 3. A facility wide sweep was conducted and it was identified that no other residents were affected by this deficient practice. A preventative maintenance program is in place for the monitoring of the call bell system to assure functionality bi-monthly. The facility failed to maintain a	11/27/17

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F 463	Continued From page 19 2.. On 8/30/17 between 2 PM and 4 PM, the call bell cord in the bathroom of room 232 was observed to be tightly wrapped around the handrail, preventing their activation. 3. On 8/30/17 between 2 PM and 4 PM, the call bell cord in the bathroom of room 318 was observed to be tightly wrapped around the handrail, preventing their activation. Findings were confirmed with E6 on 8/30/17 from 2-4 PM during the environmental tour.	F 463	properly functioning communication system. The Staff Educator will inservice nursing and housekeeping staff on ensuring the call cord is not wrapped around hand rails in the resident bathrooms. 4. The Maintenance Director/designee will conduct 10 random audits on call bell function and that the call cord is not wrapped around bathroom handrail weekly until 100% compliance is achieved for 3 months and ongoing as needed. The compliance rate will be reported at the monthly facility Safety Meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation & Healthcare Center **DATE SURVEY COMPLETED:** September 7, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from August 29, 2017 through September 7, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 98. The Stage 2 survey sample size was 25.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on September 7, 2017: F224, F225, F253, F309, F329, F385, F406 & F463.	Cross refer to CMS 2567- L F224, F225, F253, F309, F329, F385, F406, and F463	11/27/2017

Provider's Signature Eileen Nagle Title Administrator Date 9/29/2017